OFFICE OF THE STATE CONTROLLER

STATE MANDATED COSTS CLAIMING INSTRUCTIONS NO. 2006-22

AGENCY FEE ARRANGEMENTS
(COMMUNITY COLLEGE DISTRICTS)

October 6, 2006

Revised February 2, 2009

In accordance with Government Code (GC) section 17561, eligible claimants may submit claims to the State Controller's Office (SCO) for reimbursement of costs incurred for state mandated cost programs. The following are claiming instructions and forms that eligible claimants will use for filing claims for the Agency Fee Arrangements (AFA) program. These claiming instructions are issued subsequent to adoption of the program's Parameters and Guidelines (P's & G's) by the Commission on State Mandates (COSM).

On December 9, 2005, the COSM determined that test claim legislation established costs mandated by the State according to the provisions listed in the P's & G's. For your reference, the P's & G's are included as an integral part of the claiming instructions.

Eligible Claimants

Any community college that incurs increased costs as a result of this mandate, is eligible to claim reimbursement. Charter community colleges are not eligible claimants.

Filing Deadlines

A. Reimbursement Claims

A reimbursement claim is defined in GC Section 17522 as any claim filed with the State Controller's Office by a CCD for reimbursement of costs incurred for which an appropriation is made for the purpose of paying the claim.

An actual claim for the 2007-08 fiscal year, may be filed by February 15, 2009, without a late penalty. If the filing deadline falls on a weekend or holiday, the filing deadline will be the next business day. Since the 15th falls on a weekend in 2009, claims will be accepted without penalty if postmarked or delivered on before February 17th, 2009. Ongoing reimbursement claims filed after the deadline will be reduced by a late penalty of 10%, not to exceed $10,000. Amended claims filed after the filing deadline will be reduced by 10% of the increased amount not to exceed $10,000 for the total claim. Initial reimbursement claims filed after the filing deadline will be reduced by a late penalty of 10% with no limitation. Claims filed more than one year after the deadline will not be accepted by the SCO.

B. Estimated Claims

Pursuant to AB 8, Chapter 6, Statutes of 2008, the option to file estimated claims has been eliminated. Therefore, estimated claims filed on or after February 16, 2008 will not be accepted by SCO.

Minimum Claim Cost

GC section 17564(a) provides that no claim shall be filed pursuant to Sections 17551 and 17561, unless such claim exceeds one thousand dollars ($1,000).

Certification of Claim

In accordance with the provisions of GC section 17561, an authorized officer of the claimant shall be required to provide a certification of claim stating: "I certify, (or declare), under penalty of perjury under the laws of the State of California that the foregoing is true and correct," and must further comply with the requirements of the Code of Civil Procedure section 2015.5, for those costs mandated by the State and contained herein.

Audit of Costs

Pursuant to GC section 17558.5, subdivision (b), The SCO may conduct a field review of any claim after the claim has been submitted, prior to the reimbursement of the claim. to determine if costs are related to the mandate, are reasonable and not excessive, and the claim was prepared in accordance with the SCO's claiming instructions and the P's & G's adopted by the COSM. If any adjustments are made to a claim, a "Notice of Claim Adjustment" specifying the claim component adjusted, the amount adjusted, and the reason for the adjustment, will be mailed within 30 days after payment of the claim.

Pursuant to GC section 17558.5, subdivision (a), a reimbursement claim for actual costs filed by a community college district for this mandate is subject to the initiation of an audit by the SCO no later than three years after the date that the actual reimbursement claim is filed or last amended, whichever is later. However, if no funds are appropriated or no payment is made to a claimant for the program for the fiscal year for which the claim is filed, the time for the SCO to initiate an audit shall commence to run from the date of initial payment of the claim.

In any case, an audit shall be completed no later than two years after the date that the audit is commenced. All documents used to support the reimbursable activities must be retained during the period subject to audit. If an audit has been initiated by the SCO during the period subject to audit, the retention period is extended until the ultimate resolution of any audit findings. On-site audits will be conducted by the SCO as deemed necessary.

Retention of Claiming Instructions

The claiming instructions and forms in this package should be retained permanently in your Mandated Cost Manual for future reference and use in filing claims. These forms should be duplicated to meet your filing requirements. You will be notified of updated forms or changes to claiming instructions as necessary.

Questions, or requests for hard copies of these instructions, should be faxed to Angie Lowi-Teng at (916) 323-6527 or e-mailed to **LRSDAR@sco.ca.gov.** Or, if you wish, you may call the Local Reimbursements Section at (916) 324-5729.

For your reference, these and future mandated costs claiming instructions and forms can be found on the Internet at **www.sco.ca.gov/ard/local/locreim/index.shtml.**

Address for Filing Claims

Claims should be rounded to the nearest dollar. Submit a signed original and a copy of form FAM-27, Claim for Payment, and all other forms and supporting documents**. (To expedite the payment process, please sign the form in blue ink, and attach a copy of the form FAM-27 to the top of the claim package.)**

Use the following mailing addresses:

If delivered by
U.S. Postal Service:

Office of the State Controller
Attn: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

If delivered by
other delivery services:

Office of the State Controller
Attn: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
AGENCY FEE ARRANGEMENTS

For State Controller Use Only
(19) Program Number 00270
(20) Date Filed
(21) LRS Input

Program 270

(01) Claimant Identification Number			**Reimbursement Claim Data**	
(02) Claimant Name			(22) FORM-1, (04)(1)(a)(f)	
Address			(23) FORM-1, (04)(1)(b)(f)	
			(24) FORM-1, (04)(2)(f)	
			(25) FORM-1, (04)(3)(f)	
Type of Claim	**Estimated Claim**	**Reimbursement Claim**	(26) FORM-1, (06)	
	(03) Estimated	(09) Reimbursement ☐	(27) FORM-1, (07)	
	(04) Combined	(10) Combined ☐	(28) FORM-1, (09)	
	(05) Amended	(11) Amended ☐	(29) FORM-1, (10)	
Fiscal Year of Cost	(06)	(12)	(30)	
Total Claimed Amount	(07)	(13)	(31)	
Less: **Late Penalty (refer to claiming instructions)**		(14)	(32)	
Less: **Prior Claim Payment Received**		(15)	(33)	
Net Claimed Amount		(16)	(34)	
Due from State	(08)	(17)	(35)	
Due to State		(18)	(36)	

(37) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the officer authorized by the community college district to file mandated cost claims with the State of California for this program, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1098, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program. All offsetting savings and reimbursements set forth in the Parameters and Guidelines are identified, and all costs claimed are supported by source documentation currently maintained by the claimant.

The amounts for the Reimbursement Claim are hereby claimed from the State for payment of actual costs set forth on the attached statements. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature of Authorized Officer _____ Date _____

Type or Print Name _____ Title _____

(38) Name of Contact Person for Claim _____ Telephone Number _____

E-mail Address _____

Program 270	AGENCY FEE ARRANGEMENTS CERTIFICATION CLAIM FORM INSTRUCTIONS	FORM FAM-27

(01) Enter the payee number assigned by the State Controller's Office.

(02) Enter your Official Name, County of Location, Street or P. O. Box address, City, State, and Zip Code.

(03) Leave blank.

(04) Leave blank.

(05) Leave blank.

(06) Leave blank.

(07) Leave blank.

(08) Leave blank.

(09) If filing a reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing a combined reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended reimbursement claim, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of the reimbursement claim from Form-1, line (11). The total claimed amount must exceed $1,000.

(14) Reimbursement claims must be filed by **February 15** of the following fiscal year in which costs were incurred, otherwise the claims shall be reduced by a late penalty. Enter zero if the claim was timely filed, otherwise, enter the product of multiplying line (13) by the factor 0.10 (10% penalty), not to exceed $10,000.

(15) If filing a reimbursement claim or a claim was previously filed for the same fiscal year, enter the amount received for the claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16), Net Claimed Amount, is positive, enter that amount on line (17), Due from State.

(18) If line (16), Net Claimed Amount, is negative, enter that amount on line (18), Due to State.

(19) to (21) Leave blank.

(22) to (36) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (36) for the reimbursement claim, e.g., Form-1, (04)(1)(a)(f), means the information is located on Form-1, block (04)(1) (a), column (f). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, i.e., no cents. Indirect costs percentage should be shown as a whole number and without the percent symbol, i.e., 7.548% should be shown as 8. **Completion of this data block will expedite the payment process**.

(37) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the district's authorized officer, and must include the person's name and title, typed or printed. **Claims cannot be paid unless accompanied by an original signed certification**. **(To expedite the payment process, please sign the form FAM-27 with blue ink, and attach a copy of the form FAM-27 to the top of the claim package.)**

(38) Enter the name, telephone number, and e-mail address of the person to contact if additional information is required.

SUBMIT A SIGNED ORIGINAL, AND A COPY OF FORM FAM-27, WITH ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

Program 270	MANDATED COSTS AGENCY FEE ARRANGEMENTS CLAIM SUMMARY	FORM 1

(01) Claimant	(02) Type of Claim Reimbursement	Fiscal Year

Claim Statistics

(03) Leave Blank

Direct Costs	**Object Accounts**					
(04) Reimbursable Activities	(a) Salaries and Benefits	(b) Materials and Supplies	(c) Contract Services	(d) Fixed Assets	(e) Travel	(f) Total
1. Deduction & Payment of Fairshare						
a. Salary Deduction						
b. Payment of Fairshare						
2. Provision of Home Address						
3. Provision of Employee List						
(05) Total Direct Costs						

Indirect Costs

(06) Indirect Cost Rate	[Refer to Claiming Instructions]	
(07) Total Indirect Costs	[Refer to Claiming Instructions]	
(08) Total Direct and Indirect Costs	[Line (05)(f) + line (07)]	

Cost Reduction

(09) Less: Offsetting Savings		
(10) Less: Other Reimbursements		
(11) Total Claimed Amount	[Line (08) - {line (09) + line (10)}]	

Program 270	AGENCY FEE ARRANGEMENTS CLAIM SUMMARY INSTRUCTIONS	FORM 1

(01) Enter the name of the claimant.

(02) Enter the fiscal year of costs.

(03) Leave blank.

(04) Reimbursable Activities. For each reimbursable activity, enter the total from form 2, line (09), columns (d) through (h) to Form-1, block (04), columns (a) through (e) in the appropriate row. Total each row.

(05) Total Direct Costs. Total columns (a) through (f).

(06) Use the SCO FAM-29C, Flat 7%, or Federally Approved OMB A-21 methodology if specifically allowed by the P's and G's for this program. **See the Community *College Mandated Cost Manual, Section 9, Indirect Costs* for important instructions on claming indirect costs using the Federally Approved OMB A-21 Rate for electronic claims**.

(07) Enter the result of multiplying *Salaries and Benefits Only*, line (05)(a), by the *Indirect cost rate*, line (06).

(08) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (05)(f), and Total Indirect Costs, line (07).

(09) Less: Offsetting Savings. If applicable, enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(10) Less: Other Reimbursements. If applicable, enter the amount of other reimbursements received from any source including, but not limited to, service fees collected, federal funds, and other state funds, that reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(11) Total Claimed Amount. From Total Direct and Indirect Costs, line (08), subtract the sum of Offsetting Savings, line (09), and Other Reimbursements, line (10). Enter the remainder on this line and carry the amount forward to form FAM-27, line (13) for the Reimbursement Claim.

Program 270	MANDATED COSTS AGENCY FEE ARRANGEMENTS COMPONENT/ACTIVITY COST DETAIL	FORM 2

(01) Claimant	(02) Fiscal Year

(03) If filing a combined claim, enter the combined claimant name below: **Electronic Claim Only**	(04) If filing by departments with different indirect cost rates, enter the department name below: **Electronic Claim Only**
(05) Indirect Cost Rate **Electronic Claim Only**	(06) Indirect Cost Rate Base **Electronic Claim Only**

(07) Reimbursable Components: Check only one box per form to identify the component being claimed.

☐ Salary Deduction ☐ Payment of Fairshare

☐ Provision of Home Address ☐ Provision of Employee List

(08) Description of Expenses			**Object Accounts**				
(a) Employee Names, Job Classifications, Functions Performed, and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	(d) Salaries and Benefits	(e) Materials and Supplies	(f) Contract Services	(g) Fixed Assets	(h) Travel
(09) Total ☐ Subtotal ☐ Page:____of____							

Program 270	AGENCY FEE ARRANGEMENTS COMPONENT/ACTIVITY COST DETAIL INSTRUCTIONS	FORM 2

(01) Enter the name of the claimant.

(02) Enter the fiscal year for which costs were incurred. Claimant.

(03) Leave blank.

(04) Leave blank.

(05) Leave blank.

(06) Leave blank.

(07) Reimbursable Activities. Check the box which indicates the cost activity being claimed. Check only one box per form. A separate Form-2 shall be prepared for each applicable activity.

(08) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the activity box "checked" in block (03), enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, contract services, and travel expenses. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than three years after the date the claim was filed or last amended, whichever is later. If no funds were appropriated and no payment was made at the time the claim was filed, the time for the Controller to initiate an audit will be from the date of initial payment of the claim. Such documents must be made available to the State Controller's Office on request.

Object/ Sub object Accounts	Columns								Submit supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	
Salaries and Benefits Salaries	Employee Name/Title	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked					
Benefits	Activities Performed	Benefit Rate		Benefits = Benefit Rate x Salaries					
Materials and Supplies	Description of Supplies Used	Unit Cost	Quantity Used		Cost = Unit Cost x Quantity Used				
Contract Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service			Cost=Hourly Rate x Hours Worked or Total Contract Cost			Copy of Contract and Invoices
Fixed Assets	Description of Equipment Purchased	Unit Cost	Usage				Cost= Unit Cost x Usage		
Travel	Purpose of Trip Name and Title Departure and Return Date	Per Diem Rate Mileage Rate Travel Cost	Days Miles Travel Mode					Cost = Rate x Days or Miles or Total Travel Cost	

(09) Total line (08), columns (d) through (h) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the activity costs, number each page. Enter totals from line (09), columns (d) through (h) to Form-1, block (04), columns (a) through (e) in the appropriate row.